School ____________________
Grade ____________________
Teacher __________________

SEASIDE SCHOOL DISTRICT

HEALTH QUESTIONNAIRE

STUDENT NAME: ______________________________ **BIRTHDATE:** ______________________

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?	**CIRCLE ONE**	
Were there any health issues during pregnancy, delivery or first six months of life? If yes, describe:	NO	YES
Have there been any hospitalizations or surgeries? If yes, describe (include dates):	NO	YES
Allergies List known allergies:		
Are there any allergies that require use of epipen or epipen junior? If yes, what are the allergies?	NO	YES
Are there any life threatening food allergies that require dietary modification? (Appropriate medical documentation must be on file at school for food substitutions in the school meal program)	NO	YES
Special Diet Please list any dietary concerns:	NO	YES
Vision - Are there any known vision problems? Does your child wear glasses? ❑ Does your child wear contact lenses? ❑	NO	YES
Hearing – Are there any known hearing problems? Hearing devices:	NO	YES
Speech – Are there any known speech problems? If yes, describe:	NO	YES
Skin – Are there any known skin problems? If yes, describe:	NO	YES
Ear/Nose/Throat/Dental – Are there any ear, nose, throat or dental problems? If yes, describe (include dates):	NO	YES
Breathing/Lungs – Are there any known breathing or lung problems? If yes, describe:	NO	YES
Asthma? If yes, is medicine needed daily? YES ❑ NO ❑ Medication Type: ❑ Inhaler ❑ Oral Medication needed at School? YES ❑ NO❑	NO	YES
Heart – Are there any known heart problems? If yes, describe condition and list any modifications, if any, that are required:	NO	YES
Stomach/Abdominal/Intestinal – Are there any known stomach, abdominal or intestinal problems? If yes, describe:	NO	YES
Kidney/Bladder – Are there any known kidney or bladder problems? If yes, describe:	NO	YES
Neurological – Are there any known neurological problems If yes, describe:	NO	YES
Has there ever been a concussion? If yes, include dates.	NO	YES
Hormones – Have there ever been hormonal problems? If yes, describe:	NO	YES
Diabetes – Does your student have diabetes? If yes, will your student require insulin in school? Breakfast? ❑ Lunch? ❑ Afternoon? ❑ Will your student require assistance with diabetes management? YES ❑ NO ❑	NO	YES
Behavior/Psychiatric – Are there any known behavior or psychiatric problems? If yes, describe:	NO	YES
Medication – List all medications that your student takes on a daily basis:		
Which prescription medications will your student need to take during school hours?		
Please list anything else that you think the school health specialist should know about your student:		

Parent/Guardian Signature: ______________________________ **Date:** ____________________

If you would like to speak with the school health specialist, please call (503) 738-5591